DEPARTMENT OF HEALTH AND HUMAN SERVICE	ES
CENTERS FOR MEDICARE & MEDICAID SERVICE	ES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPI 05/11/2	
		155298	B. WIN			05/11/2	011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CAMBBII		SING & REHABILITATION CENTE	:D		OWNSHIP LINE RD APOLIS, IN46260		
					AFOLIS, 11140200		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
F0000	REGGE/HORT OR	ESC IDENTIFY TING IN ORMATION	1	1710			DATE
1.0000							
	This visit was for	r Investigation of	F ₀	000			i
	Complaints IN00						
	IN00090306.	, 00, 10, 4114					
	11 (000) 05 00.						
	Complaint number	er IN00089189					
	•	deral/state deficiencies					
	•	egations are cited at F225					
	and F226.	Squitoris are cited at 1 222					
	una 1 220.						
	Complaint IN000	090306 unsubstantiated					
	due to lack of evi						
	due to luck of evi	idence.					
	Survey date: May	y 10, 11, 2011					
	Facility number:						
	Provider number:	: 155298					
	AIM number: 10	00267690					
	Survey team:						
	Charles Stevenso	on RN					
	Charles Stevenso	AL CO					
	Census bed type:						
	SNF/ NF: 91						
	Total: 91						
	10111. 71						
	Census payor typ	oe:					
	Medicare: 14	· · ·					
	Medicaid: 62						
	Other: 15						
	Total: 91						
	10001. 71						
	Sample: 3						
LABORATOR	Y DIRECTOR'S OR PROV	TDER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		TITLE		(X6) DATE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7KE411

Facility ID:

000195

If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155298		(X2) MULTIPLE CO A. BUILDING B. WING	00		E SURVEY PLETED 2011	
NAME OF PROVIDER OR SUPPLIER CAMBRIDGE MANOR NURSING & REHABILITATION CENTER			8530 T	ADDRESS, CITY, STATE, ZIP CO OWNSHIP LINE RD NAPOLIS, IN46260	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	findings cited in 16.2.	es also reflect state accordance with 410 IAC ompleted 5-13-11 RN				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155298		(X2) MULT A. BUILDI B. WING		OO	(X3) DATE S COMPL 05/11/2 0	ETED	
NAME OF F	PROVIDER OR SUPPLIER		S		DDRESS, CITY, STATE, ZIP CODE		
CAMBRII	DGE MANOR NURS	SING & REHABILITATION CENTE			WNSHIP LINE RD APOLIS, IN46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1 1	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL	1	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	T	AG	DEFICIENCY)		DATE
F0225 SS=D	have been found gor mistreating residuals have had a finding nurse aide registry mistreatment of resoftheir property; a has of actions by a employee, which we service as a nurse the State nurse aid authorities.	ot employ individuals who guilty of abusing, neglecting, dents by a court of law; or gentered into the State or concerning abuse, neglect, sidents or misappropriation and report any knowledge it a court of law against an awould indicate unfitness for eaide or other facility staff to de registry or licensing					
	violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).						
	alleged violations	ave evidence that all are thoroughly investigated, further potential abuse while in progress.					
	The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.						
	Based on record facility failed to potential verbal a investigating and	review and interview, the protect residents from abuse by not thoroughly reporting to the State ared by State law an	F022	5	Preparation and/or execution this plan of Correction in gen or any corrective action does constitute an admission or agreement by Cambridge Ma Healthcare and Rehabilitation	eral, not anor	06/10/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DAT			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPI	LETED
		155298	A. BUII			05/11/2	011
			B. WIN		ADDRESS STEV STATE ZID SODE		
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
				1	OWNSHIP LINE RD		
CAMBRI	IDGE MANOR NUR	SING & REHABILITATION CENTE	=R	INDIAN	APOLIS, IN46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	allegation of sta	ff verbal abuse for 1	Ī		Center of the facts alledged	or the	
	resident of 3 rev	iewed for investigation			conclusions set forth in the		
		unusual occurrences.			statement of deficiencies. T		
	(Resident B)	unusuar occurrences.			Plan of Correction and spec		
	(Resident B)				corrective actions are prepa		
					and/or executed soley beca		
	Findings include	e:			the provision of federal or state laws.Cambridge Manor	alt	
					Healthcare and Rehabilitation	nn .	
	The record of R	esident B was reviewed			desires this plan of correction		
	on 5/10/11 at 1:00 p.m.				be considered the facility's		
	011 37 107 11 46 1.0	50 p.m.			allegation of compliance.		
					Futhermore, we also reques	st	
	1 ~	ded, but were not limited			desk/paper compliance in		
	to, hypertension	, anemia, arthritis, and			rectifying the deficiency, as	it was	
	gastro- esophage	eal reflux disease.			an isolated incident, with the		
					alleged offender no longer v		
	Resident R was	admitted to the facility			the facility.Element #1:It is t		
		ite care hospital stay on			policy of this facility to see the		
	1	2			residents are protected from	-	
		the facility by her choice			form of abuse or potential a This includes, but is not limi		
	in the company	of her family on 4/09/11.			thouroughly investigating ar		
					reporting to the State Agend		
	A facility "Griev	vance/Concern Form"			required by state law any	,,	
	dated 4/09/11 in	dicated:			allegation of staff abuse.Re	sident	
					B no longer resides in facilit		
	"Pagidant Nama	: (Resident B's name)			#1 no longer employed by tl	his	
	Resident Name	. (Resident B's name)			facility.Element #2:All reside		
					had the potential to be affect	ted by	
		Concern: Res (resident) c/o			the actions of this LPN. As		
	(complained of)	Nurse (LPN #1) was			Stated prior, this LPN is no	-	
	abrasive/defensi	ve and rude when CNA			employed by the facility. A wide audit was done by soc		
	relayed that Res	. wanted her assist for			services and our nursing sta		
	toileting				during which interviewable	A11,	
	toneung				residents were asked about	their	
	Investigation/Follow-Up: DON (Director				treatment and the attitude o		
					staff towards them. Further		
	of Nursing) call	ed to room after CNA			for non-interviewable reside		
	(CNA #2) came	from pts (patient's) room			attempts were made to conf	tact as	
	(symbol for "wi	th") complaint staff nurse			many responsible parties as	3	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155298	B. WIN			05/11/2	011
		<u> </u>	F		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	₹			OWNSHIP LINE RD		
	DGE MANOR NUR	SING & REHABILITATION CENTE	R		APOLIS, IN46260		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ATE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	+	TAG	,	_	DATE
being rude, disrespectful and made her				possible to inquire as to thei feelings about staff's actions			
		too much bother and the			their attitudes toward their fa		
	1	sy. Family removed res.			members. Additionally, staf	•	
	from the facility	and took her home."			asked if they had any conce	rns	
					as to any display of rude or		
	Nurse's notes da	ted 4/09/11 at 5:45 p.m.			disrespectful verbalizations		
	indicated "CNA	relayed that res. upset and			treatment by any staff to any resident. Element #3: At an a		
	requested to spea	ak to DON. DON spoke			inservice, the following was	ota	
	(symbol for "wit	h") res. regarding this			reviewed:1. Abuse Policy2.		
	complaint of hove	w the assigned nurse was			Resident Rights3. What do	you	
	1 ^	Daughter in and concerns			do if you think you have		
	1 ^ ~	Family and res. insistent			witnessed or been told abou abuse or potential abuse?4.		
	that they were le	3			Investigation of abuse or po		
	litat they were re	4 1 115 11			abuse5. Reporting abuse o		
	During interview	vs on 5/10/11 at 10:50			potential abuse (Including w		
	1 -	on 5/11/11 at 3:30 p.m.,			to report, whom to report to,	why	
		strator and Director of			it must be reported.6. Questions/AswersAny staff	who	
					fail to comply with the points		
		.) present, the D.O.N.			the inservice will be further		
	1	d spoken with Resident B			educated and/or progessive		
	1	hat she had spoken with			disciplined as appropriate.		
	1	A #2, and that she had			facility maintains a zero tole for any abuse. Element #4:A		
	1 ^	Grievance/Concern Form"			monthly Quality Assurance a		
	dated 4/9/11. Th	e D.O.N. indicated she			incidence of abuse or allege		
		wed any other residents,			abuse will be reviewed to be		
	1	members, to determine if			certain all protocols were		
	any other resider	nts had experienced any			followed. Any patterns will be		
	incidents of abus	se, had concerns about the			identified. If necesarry an a plan will be written by a	CUON	
	incident involvir	ng Resident B, or if they			committee appointed by the		
	felt safe in the fa	icility, or if staff or family			administrator to address any		
	had any concerns. Staff were not assessed to determine their knowledge of facility policies and procedures concerning				concerns. The plan will be		
					monitered weekly until resol		
					is achieved. Any findings from audit or any further similar	ii this	
	standards of prac	_			allegations will be acted on		
		ent abuse or reporting of			immediately and reported to	the	
	Preventing resid	ent abuse of reporting of			,		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155298		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 05/11/2011			ETED		
	PROVIDER OR SUPPLIER	I SING & REHABILITATION CENTE	·	STREET AI	DDRESS, CITY, STATE, ZIP CODE DWNSHIP LINE RD APOLIS, IN46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ſĒ	(X5) COMPLETION DATE
	incident had not	use. She indicated the been reported to the State red by regulation and			state.Going forward, any complaint of any form of abu alleged abuse will be immediand thouroughly investigated reported as per policy and regulations.	iately	
F0226 SS=D	written policies and mistreatment, negrand misappropriated Based on record facility failed to protected from protected abuse as refacility policy for investigation occurrences. (Refindings include 1. An undated far "Reportable Unureceived from the 5/10/11 at 3:45 protected from the 5/10/11 at 3:45 protected from the facility protected from	cility policy titled sual Occurrences" e Administrator on .m. and indicated to be a	F0	226	Preparation and/or execution this plan of Correction in gen or any corrective action does constitute an admission or agreement by Cambridge Ma Healthcare and Rehabilitation Center of the facts alledged conclusions set forth in the statement of deficiencies. The Plan of Correction and specific corrective actions are preparand/or executed soley becaute provision of federal or stallaws. Cambridge Manor Healthcare and Rehabilitation desires this plan of correction be considered the facility's allegation of compliance. Futhermore, we also request desk/paper compliance in rectifying the deficiency, as if an isolated incident, with the alleged offender no longer with facility. Element #1:It is the policy of this facility to see the residents are protected from	eral, anot anor nor the fic red use of ate nor to t was ith see at all	06/10/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155298	B. WIN			05/11/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	8		1	OWNSHIP LINE RD		
CAMBRI	DGE MANOR NUR	SING & REHABILITATION CENTE	ER	1	APOLIS, IN46260		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	F	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	compliance with	State and Federal laws.			form of abuse or potential ab		
	_				This includes, but is not limite		
	Policy: Facility intends to be in				thouroughly investigating and		
	1	the laws governing			reporting to the State Agency	/ as	
	_				required by state law any allegation of staff abuse.Res	idont	
	1 ^	al occurrences through			B no longer resides in facility		
	adherence of the	policy of the ISDH.			#1 no longer employed by th		
					facility.Element #2:All resider		
	Procedure: Facil	ity will report unusual			had the potential to be affect		
	occurrences with	nin 24 hours to the Long			the actions of this LPN. As		
	Term Care Divis	ion of the ISDH of			Stated prior, this LPN is no lo		
	alleged violations involving mistreatment,				employed by the facility. A fa		
	neglect or abuse	_			wide audit was done by socia		
	liegicet of abuse	of residents			services and our nursing state during which interviewable	Ι,	
	1 . 1 . 1				residents were asked about t	heir	
		ity policy titled "Abuse			treatment and the attitude of		
		esponse Policy" received			staff towards them. Further,		
	from the Admini	strator on 5/10/11 at 3:45			for non-interviewable resider		
	p.m. and indicate	ed to be a current facility			attempts were made to conta	act as	
	policy indicated:				many responsible parties as		
					possible to inquire as to their		
	"Policy: Abuse	as hereafter defined, will			feelings about staff's actions their attitudes toward their fa		
	I -	by anyone, including			members. Additionally, staff	-	
	staff	by anyone, merading			asked if they had any concer		
	Starr				as to any display of rude or		
					disrespectful verbalizations of	or	
		ninistrator is responsible			treatment by any staff to any		
		patient safety, including			resident.Any findings from th	is	
	freedom from ris	sk of abuse, holds the			audit or any further similar		
	highest priority.				allegations will be acted on immediately and reported to	the	
					state.Going forward, any	u 10	
	Definitions3: V	Verbal Abuse: the use of			complaint of any form of abu	se or	
					alleged abuse will be immed		
	oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their				and thouroughly investigated	and	
					reported as per policy and		
	1 -				regulations.Element #3:At ar		
	· ·	in their hearing distance			staff inservice, the following	was	
	regardless of the	ir age, ability to			reviewed:1. Abuse Policy2.		

FORM APPROVED OMB NO. 0938-0391

PRINTED:

06/09/2011

OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155298 05/11/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8530 TOWNSHIP LINE RD CAMBRIDGE MANOR NURSING & REHABILITATION CENTER INDIANAPOLIS, IN46260 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE comprehend or disability. Resident Rights3. What do you do if you think you have witnessed or been told about Identification Issues: abuse or potential abuse?4. Investigation of abuse or potential abuse5. Reporting abuse or Policy: Any resident event that is reported potential abuse (Including when to any staff by resident, family member, to report, whom to report to, why other staff, or any other person will be it must be reported.6. considered POSSIBLE ABUSE if it meets Questions/AswersAny staff who any of the following criteria: fail to comply with the points of the inservice will be further educated and/or progessively E. Any complaint of the use of oral, disciplined as appropriate. The written or gestured language that willfully facility maintains a zero tolerance includes disparaging and derogatory terms for any abuse. Element #4: At the monthly Quality Assurance any to resident or families or within their incidence of abuse or alleged hearing distance. abuse will be reviewed to be certain all protocols were followed. Any patterns will be Investigative Issues: identified. If necesarry an action plan will be written by a 3. Policy: All events reported, as possible committee appointed by the abuse will be investigated to determine administrator to address any whether abuse did or did not take place. concerns. The plan will be monitered weekly until resolution is achieved. Reporting and Response Issues: 1. Policy: All reports of abuse or alleged abuse will be immediately assessed to determine the direction of the investigation. 2. Procedure: Any investigation that substantiates abuse or neglect or alleged abuse or neglect findings will be reported immediately to the Administrator or

his/her designated representative and to

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Ì		INSTRUCTION 00	(X3) DATE S COMPLE		
1111212111	or conditions	155298		ILDING		05/11/20	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				OWNSHIP LINE RD		
CAMBRI	DGE MANOR NURS	SING & REHABILITATION CENT	ΓER	INDIAN	APOLIS, IN46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION DATE
IAG		accordance with State		IAG			DAIL
	Law"	accordance with State					
	Luw						
	2. The record of	Resident B was reviewed					
	on 5/10/11 at 1:0	0 p.m.					
	Diagnoses includ	led, but were not limited					
	to, hypertension,	anemia, arthritis, and					
	gastro- esophage	al reflux disease.					
		admitted to the facility					
	1	te care hospital stay on					
		the facility by her choice					
	in the company of	of her family on 4/09/11.					
	A facility "Griev	ance/Concern Form"					
	dated 4/09/11 ind						
	dated 1703711 inc	aroutou.					
	"Resident Name:	(Resident B's name)					
	D 22	D (:1 : > /					
		oncern: Res (resident) c/o					
	`	Nurse (LPN #1) was ye and rude when CNA					
		wanted her assist for					
	toileting	wanted her assist for					
	tonoung						
	Investigation/Fol	llow-Up: DON (Director					
		d to room after CNA					
		from pts (patient's) room					
		h") complaint staff nurse					
	being rude, disre	spectful and made her					
	feel like she was	too much bother and the					
		sy. Family removed res.					
	from the facility	and took her home."					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155298	B. WIN			05/11/2	011
			_		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		8530 TO	OWNSHIP LINE RD		
		SING & REHABILITATION CENT	ER		APOLIS, IN46260		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	H DEFICIENCY MUST BE PERCEDED BY FULL LATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)		PRIATE	
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		. 1 4/00/11 5 45					
		ted 4/09/11 at 5:45 p.m.					
		relayed that res. upset and					
	1 -	ak to DON. DON spoke					
	l · -	h") res. regarding this					
	complaint of hov	w the assigned nurse was					
		Daughter in and concerns				l	
	addressed again.	Family and res. insistent					
	that they were le	aving"					
	During interview	vs on 5/10/11 at 10:50					
	a.m., and again of	on 5/11/11 at 3:30 p.m.,					
	with the Admini	strator and Director of					
	Nursing (D.O.N.	.) present, the D.O.N.					
	1	d spoken with Resident B					
		hat she had spoken with					
	1	A #2, and that she had					
		Grievance/Concern Form"					
	1 ^	e D.O.N. indicated she					
		wed any other residents,					
		members, to determine if					
	· ·	nts had experienced any					
	1 *	se, had concerns about the					
		ng Resident B, or if they					
		cility, or if staff or family					
	1 *	s. Staff were not assessed					
		ir knowledge of facility					
	1	cedures concerning					
	standards of prac	· ·					
		ent abuse or reporting of					
	1 ~	use. She indicated the					
	incident had not	been reported to the State					
	Agency as requir	red by regulation and					
	facility policy.						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP - 05/11/2	LETED
NAME OF PROVIDER OR SUPPLIER CAMBRIDGE MANOR NURSING & REHABILITATION CENTER			8530 T	ADDRESS, CITY, STATE, ZIP COI OWNSHIP LINE RD IAPOLIS, IN46260	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	3.1-28(a)					